Palliative Care Conference Summary

Name of Resident: _____ Date of Birth: ____/____/____
(DD/ MM/ YYYY)

Name of Physician: _____

Data to collect prior to palliative care conference:

Current PPS score: _____

Primary diagnosis (list relevant comorbidities as applicable): _____

_____

Applicable illness trajectory (check all applicable):

☐ Frailty ☐ Dementia ☐ Lung disease ☐ Kidney disease ☐ Heart failure ☐ Other:

Resource(s) provided to resident/family:
☐ Illness trajectory pamphlet(s)
☐ Comfort care booklet (dementia and other neurological disease)
☐ Question prompt list (dementia and other neurological disease)
☐ Other

Previously expressed goals of care/known wishes regarding CPR, disease modifying treatments, etc.:

_____

Within the past year:

Details of any hospitalizations:

_____

_____

Details of any infections:

_____

_____

Number of falls: _____

Oral intake has: ☐ Increased ☐ Decreased ☐ Remains unchanged

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Has the resident lost weight? ☐ Yes ☐ No ☐ If yes, % of weight loss _____

Participants:

Resident in attendance? ☐ Yes ☐ No

Note: If the resident has capacity to make decisions related to palliative care, the resident must be present for a palliative care conference to take place. Others may also be included with the resident's permission.

Resident's substitute decision maker (SDM) in attendance? ☐ Yes ☐ No

Note: If the resident does not have the capacity to make healthcare decisions, the resident's SDM must be present for a palliative care conference to take place.

Others attending to support the resident? ☐ Yes ☐ No

Note: The resident may choose to involve other family and friends in healthcare conversations.

Resident's Family or Other Support Persons (to be invited by the resident or SDM, as applicable)

Name	Relationship and Contact Info as applicable

Health Care Providers (Check all in attendance)

Names and roles			
☐ Nurse (LPN, NP, RPN, RN)		☐ Physician	
☐ Care assistant (HCA, PSW)		☐ Manager or coordinator	
☐ Dietitian		☐ Dietary aide/kitchen staff	
☐ Recreation (coordinator, therapist, worker, or aide)		☐ Spiritual care (e.g., elder, chaplain, pastor, rabbi, imam)	
☐ Occupational therapist or assistant		☐ Physiotherapist or assistant	
☐ Social worker		☐ Pharmacist	
☐ Palliative consultant		☐ Palliative care volunteer	
☐ Other:		☐ Other:	

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Key Issues Discussed & Wishes or Goals Shared

Symptoms
Social/psychological/spiritual needs
Assessments/investigations
Other (e.g., end of life planning)

Care Planning

Care Plan Items	Actions	Key Person(s) responsible	Review date

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Follow up items

Item to be followed up	Key Person(s) responsible	Resolution	Date follow up completed

Conference start time: _____ End time: _____

Check when completed:

- ☐ Original placed in the resident's clinical notes
- ☐ Copy sent to physician
- ☐ Copy offered to participating allied health professionals
- ☐ Copy offered to the resident/SDM
- ☐ Resident's care plan and assessments reviewed and updated

Facilitator's Name: _____

Position: _____Signature: _____ Date: ___ /___ /_____/
(DD/MM/YYYY)